STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345431	A. BUILDING _____ B. WING _____	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR COMMUNITY HOSPITAL	921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff the facility failed to protect 2 alert and oriented residents (Resident #24 and Resident #3) and one cognitively impaired resident (Resident #28) from verbal abuse by an alert and oriented resident (resident #26). The findings included: The facility's Abuse Prevention Policy dated 7/2/07 read in part. "Each resident has the right to be free from verbal, sexual, physical and mental abuse ..." The Abuse Investigation, Protection and Reporting Policy read in part, "Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents ..." Resident #26 was readmitted to the facility on 3/22/11 with diagnoses which included emotional disorders, hemiplegia of the left side, chronic pain syndrome and diabetes mellitus. The quarterly Minimum Data Set (MDS) dated 9/26/15 revealed Resident #26 was cognitively intact and had verbal behaviors towards others. She required extensive to total assistance with all activities of daily living (ADLs). She had functional limitations of the upper and lower extremities on one side and required extensive	F 223	1.) Corrective action for resident's #3, 24 and 28 from resident #26. These residents have been assessed for any physical or emotional distress as well as any depressive feelings as result of resident #26's verbal abuse. Each resident reports that they are "doing well" and haven't given the incident much thought. Interview with resident's done on 12-7-15. Minimum Data Set (MDS) RN, Assistant Director of Nursing (ADON), Social Worker (SW) There have been no further incident of verbal abuse by resident #26 toward residents #3, 24 or 28. (12-7-15) 2.) Corrective action for other residents having potential to be affected: a.) If resident to resident abuse is witnessed or reported, the offending resident will be safely and immediately removed from the situation. The resident being verbally abused will be assessed by the charge nurse for any type of residual	12/7/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/11/2015

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F 223	Continued From page 1 assistance for locomotion in her wheel chair. Resident #26's care plan with a review date of 10/7/15 revealed a problem category of Behavioral Symptoms with a problem start date of 12/31/14. The care plan indicated she "exhibited verbal behavioral symptoms directed towards others. Persistent anger with others if she doesn't get what she wants immediately (e.g., threatening others, screaming at others, cursing at others)." The approaches included "during outbursts of yelling/cursing, remove resident from situation if possible and allow resident to have some calm down time and refocus conversation when resident becomes verbally abusive." The goal was listed as "Resident will lessen threaten, scream at or curse at other residents, visitors and/or staff." The monthly nursing summaries from 1/21/15 through 10/18/15 documented behavioral symptoms which listed verbally abusive as one of the symptoms on all 10 of the monthly summaries. A review of Resident #26's medical record revealed a note dated 8/6/15 from the physician which revealed she had recently failed GDR (gradual dose reduction) and was started on Geodon and had shown improvement. Another note dated 10/18/15 from the physician revealed she was observed by the physician and she "was very aggressive, cursing and making derogatory statements and very accusatory." The note also stated, "Even argumentative with elderly, demented patients. Will adjust her Geodon and increase the dosage starting tomorrow." Additional medical record review revealed a note from the DON dated 10/20/15 at 4:15 PM which stated Resident #26 was argumentative with staff and other residents. She was brought out of the dining room briefly after verbal confrontation with	F 223	effects, physical or emotional. The incident(s) are reported to the resident's physician. The charge nurse or the social worker (SW) will notify facility psychiatric services for consultation and/or recommendations per physician order. the offending resident's family or responsible party (RP) will be notified. Every attempt is made to maintain the safety of all residents and to protect their rights. If the offending resident(s) continue to abuse a resident(s), the facility will make every attempt to remove that resident from the facility either for inpatient psychiatric admission if indicated or discharge from facility if the safety and well-being of other residents is in jeopardy. (Director of Nursing-DON, Social Worker-SW, Administrator-Adm 12/14/15) In-service on resident abuse provided to all staff: 12/11/15, 12/14/15, 12/15/15, 12/16/15 (ADON, DON, SW, Staff Development Coordinator) 3.) Measures put into place to ensure incident will not occur: a.) Abuse policy in-services will be done every 6 months. Policy review with all new employees during their 90 day probation period. (SDC, DON, RN, Administrator 12/11/15) b.) Addendum to facility Abuse Prevention Policy updated on 12/1/15 to include actions to do following an incident of resident to resident abuse:	

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F 223	Continued From page 2 another resident. "Her behaviors and verbally abusive language is upsetting to other residents and to their families as well." A review of the incidents provided by the facility revealed the use of Behavior Outburst Forms which were used to document "Assault of Another Resident or Staff Member". 1. Resident #24 was interviewed on 11/3/15 at 9:18 AM. A quarterly MDS dated 10/11/15 revealed she was cognitively intact and had no behaviors exhibited. She reported one of the other residents was verbally abusive. She stated she had been called derogatory names and curse names by Resident #26. She stated she would just move away but most of the time as soon as Resident #26 saw her she would call her names. She stated Resident #26 knew what she was doing because she had even cursed at one of her visitors when the visitor would not give her money for a soda. During an interview with Resident #24 on 11/5/15 at 9:10 AM she stated that resident #26 had cursed at her and called her derogatory names about 3 weeks ago. She stated she went to her room and "cried and prayed." She stated, "You can only try so hard with her" and it was a "mind game" for Resident #26 because there was nothing wrong with Resident #26's mind or memory because she knew everyone's name. Resident #24 did not report the interaction to any staff member. Resident #24 added, "It stresses me to see it done to other residents" when #26 calls them curse names. Resident #24 reported she tried to talk to the resident who was on the receiving end of the name calling. She stated she witnessed when Resident #26 called Resident #28 curse names during the Resident Council meeting. Resident #24 added that she "felt embarrassed by the actions of her (Resident	F 223	1. Separate residents 2. Offending resident will be taken to his/her room for time out-no longer than 15 minutes-light on, call bell within reach, door to remain open and explanation given to the resident for the actions being taken 3. Assessment of resident who has been abused for physical injuries or emotional distress 4. DON and administrator to be notified 5. MDS nurse to be notified as soon as possible and care plan will be initiated 6. Family and responsible party of all residents involved will be notified 7. Incident Report and Behavior Outburst Report to be completed by whomever witnesses the incident and given to charge nurse (CN). Documentation in residents electronic medical record (EMR) by CN c.) Minimum Data Set (MDS) will be updated. d.) Follow-up with abused resident(s) for at least 72 hours with documentation in EMR. (Charge nurses, Social Worker 12/11/15-ongoing) 4.) Monitoring to ensure compliance: The DON or facility SW will report any incidents of resident to resident abuse at the weekly Risk Meeting as they occur with corrective measure initiated. The	

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F 223	Continued From page 3 #26) calling others names." On 11/13/15 at 11:15 AM Resident #24 stated she did not feel harmed or threatened. She reported she had not changed any patterns due to Resident #26. 2. A record review of a Behvior Outburst Form dated 6/25/15 at 3:00 PM revealed Resident #26 called Resident #3 curse names but Resident #3 did not curse back but stated Resident #26 was a "bad person." The nurse then removed Resident #26 from the nursing station. The form went on to document the incident had occurred 2 or more times within the past week. The staff action was documented as removed resident and that the nurse explained to the resident the importance of respect for fellow residents. To avoid such an incident in the future was documented as remove resident during outburst. The form was reviewed by the Director of Social Services who documented she spoke with Resident #26 about her behaviors and told her how offensive her name calling was. The Director of Nursing (DON) reviewed the form and documented the resident was removed from other residents temporarily. The DON also documented Resident #26 had had several episodes of verbal aggression that week and that no amount of talking to or trying to reason with her helped. Resident #3 was interviewed on 11/3/15 at 10:40 AM. Her quarterly MDS dated 10/4/15 revealed she was cognitively intact and had no exhibited behaviors. She stated Resident #26 had called her a curse name. Resident #3 stated she had given another resident 2 flower pots and when that resident died she asked the DON for permission to get the flower pots back. Resident #3 stated Resident #26 cursed at her and called her curse names and a liar over the flower pots. She stated the cursing and derogatory name	F 223	SDC will schedule in-services at least every 6 months; more often as needed, on resident abuse. Using the Abaqis Quality Assurance and Performance Improvement Program, the DON and the ADON will review responses by residents through reports generated from data entered and analyzed by the Abaqis Management System. This system identifies residents who have experienced any type of abuse. Written report with trends and analysis will be presented to facility Quality Assurance Committee on a monthly basis. (DON - 12/2/15)	

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calling was worse now than in the past. She stated being cursed at by Resident #26 made her "feel bad."
On 11/4/15 at 3:55 PM Resident #3 stated Resident #26 called her a curse name. She stated she knew that she was not what she was called but it made her so angry she wanted to hit Resident #26 in the mouth but she knew she could not do that. She stated she thought "this facility was a place to rest and relax but Resident #26 made it so you can't." She stated Resident #26 had not cursed at her since 2 weeks ago but, if she had somewhere else to go she would. She then stated she felt Resident #26 was the one who should have to go somewhere else and that she was "not good for any of the residents here."
During an interview with resident #49 on 11/5/15 at 11:02 AM he stated he heard Resident #26 cursing at Resident #3 when she called Resident #3 a derogatory name and a curse name. He stated it made him feel bad for Resident #3 and that the "residents should not have to put up with verbal abuse." He added, "It is verbal abuse." He stated she had not cursed at him. He stated he talked to Resident #3 to provide support and told her "to keep on going and to ignore Resident #26." Resident #49 then stated that Resident #26 "is nice since the state is here."
On 11/6/15 at 11:28 AM the Director of Social Services (DSS) stated she witnessed when Resident #26 cursed at Resident #3 calling her a curse name.
On 11/13/15 at 11:40 AM pm Resident #3 stated she did not stop attending any of the out of room activities due to Resident #26. Resident #3 stated she did not feel harmed or threatened by the verbal altercation with Resident #26.
3. Resident #28's quarterly MDS dated 10/12/15 revealed she was severely cognitively impaired

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and had no exhibited behaviors.
On 11/6/15 at 11:19 AM the Activities Director (AD) stated that last week Resident #26 called Resident #28 a curse name as she was backing out of the dining room. She stated that Resident #28 seemed upset because of the way she started moving her arms. The AD stated that during the last Resident Council Meeting either on 10/28/15 or 10/29/15 she had to interrupt a verbal altercation between these 2 residents and told them this was not the place so that stopped the incident from escalating. The AD stated it was verbal abuse when Resident #26 called other residents names. The AD stated she did not complete a Behavior Outburst Form.
Resident #49 was interviewed on 11/3/15 at 9:50 AM. His quarterly MDS dated 8/14/15 revealed he was cognitively intact and had no exhibited behaviors. Resident #49 stated Resident #26 had not called him derogatory names but he had heard her fuss and call other residents derogatory names and curse names.
On 11/13/15 at 11:00 AM Resident #49 reported that Resident #26 had fussed with Resident #28 during the Resident Council meeting and that he had made the comment, "Why can't we just get along." Resident #49 stated both the other residents quieted down and stayed for the meeting. Resident #49 stated he had not felt harmed or changed any of his out of room activities due to Resident #26.
Nurse #3 was interviewed on 11/5/15 at 7:32 AM and she stated she had heard Resident #26 call another resident a curse word. She stated Resident #26 did it when she was mad because she did not get her way. She stated Resident #26 was oriented and was aware of what she was doing. She stated she had explained to Resident #26 that cursing and name calling was

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inappropriate behavior. She stated reducing stimulation would reduce the behavior.
On 11/5/15 at 11:28 AM the DON stated they completed Outburst Forms for the behaviors of Resident #26 and that the facility had discussed her in numerous facility meetings. She stated they had tried numerous things including medication adjustments and had contacted other facilities that could "accommodate someone like her." The DON stated they had tried everything they could think of but nothing had worked.
On 11/6/15 at 11:28 AM the Director of Social Services (DSS) stated when Resident #26 called other residents curse names and derogatory names it was "bad verbal abuse." She stated the facility had a group staff meeting and they had tried different medications to "try to level out her behaviors." The DSS stated she felt the facility "was in a catch 22 with medication adjustments and outburst from Resident #26." She stated the facility had arranged for Resident #26 to get help from an outpatient psychiatric physician to help with her psychiatric concerns. Medical record review provided documentation that Resident #26 was seen by out-patient psychiatric services and medication changes were made but the resident refused to take some of the medications as prescribed.
During an interview on 11/6/15 at 12:35 the DON stated Resident #26 had cussed at other residents and that was verbal abuse.
On 11/13/15 at 6:00 PM the DON stated the facility doctor was working with a psychiatrist and the pharmacist to find a medication combination that would work for Resident #26 but "it was a lot of trial and error." Some of the medication changes made Resident #26 worse and other changes made her too sleepy so the medications had to be readjusted. She added that some of

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F 223	Continued From page 7 Resident #26's behaviors were manipulation.	F 223		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff the facility failed to follow their policy and procedure for investigating allegations of verbal abuse for 1 resident (Resident #26) who was calling other residents derogatory names and curse names. The findings included: A review of the facility policy titled "Abuse Prevention" with a revision date of 7/2/07 read in part "Each resident has the right to be free from verbal ... abuse. Residents must not be subjected to abuse by anyone, including, but not limited to ... other residents ..." A review of the facility policy titled "Abuse Investigation, Protection, and Reporting" with a revision date of 7/2/10 read in part "Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families or within their hearing distance ..." In the section titled "Training of Staff Members" it read in part "All staff members shall receive a minimum of 2 hours of initial orientation training and ongoing training during the year regarding the following aspects of abuse: How to manage residents with aggressive or catastrophic behaviors." In the	F 226	1.) The Abuse Prevention Policy has been updated to include actions to be followed after an incident of resident to resident occurs. The facility is in the process of in-servicing all staff on this policy and the updates to it. (Director of Nursing (DON), ADON, SDC, Administrator - 12/9/15, 12/10/15, 12/11/15, 12/14/15, 12/15/15) 2.) Corrective action for other residents: a.) There have been no incidents of resident to resident abuse during the past 30 days, but if an incident occurs the facility will follow its policy on Resident Abuse Prevention and Abuse Investigating. b.) The facility will identify , correct and intervene in situations in which abuse is likely to occur. c.) The facility is being more diligent in training and educating staff through the	12/22/15

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section titled "Prevention of Abuse" it read in part: "The facility will identify, correct and intervene in situations in which abuse is more likely to occur. The interdisciplinary care plan process shall be used to target those residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors ..." In the section titled "Identification of Abuse" it read "Events such as ...patterns and trends that may constitute abuse shall be investigated through the facility Incident/Accident process and reported to Quality Assurance Committee monthly."
Resident #26 was readmitted to the facility on 3/22/11 with diagnoses which included emotional disorders, hemiplegia of the left side, chronic pain syndrome and diabetes mellitus.
The quarterly Minimum Data Set (MDS) dated 9/26/15 revealed Resident #26 was cognitively intact and had verbal behaviors towards others. She required extensive to total assistance with all activities of daily living (ADLs). She had functional limitations of the upper and lower extremities on one side. She required extensive assistance for locomotion in her wheel chair.
Resident #26's care plan with a review date of 10/7/15 revealed a problem category of Behavioral Symptoms with a problem start date of 12/31/14. The care plan indicated she "exhibited verbal behavioral symptoms directed towards others. Persistent anger with others if she doesn't get what she wants immediately. (e.g., threatening others, screaming at others, cursing at others)." The approaches included "during outbursts of yelling/cursing, remove resident from situation if possible and allow resident to have some calm down time and refocus conversation when resident becomes verbally abusive." The goal was listed as "Resident will lessen threaten,

in-services currently in progress, both in groups and one on one with employees.

d.) Employees will have a better understanding of and the importance of following our policy. (DON, ADON, SDC, Administrator)

e.) The MDS nurse understands the process of coding the MDS accurately and updating resident care plan after any incident or resident to resident abuse and is expected to comply. (MDS nurse, DON - 12/7/15)

f.) DON will report to the weekly Risk Meeting any incidents of resident abuse. Corrective actions/interventions will be discussed with committee members and MDS will update care plan if needed. (DON, SW, MDS nurse, Committee members - 12/8/15)

g.) All disciplines will be involved in assisting with incidents of abuse and will help identify behaviors noted by them, whether during activities, in dining room, in room, etc.

3.) Measures put into place to prevent reoccurrences of this event:

1.) The facility will continue to be more proactive in educating staff on abuse and their importance of reporting and potential consequences for not reporting. In-services will be provided and mandatory for all staff at least every 6 months. All new

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F 226	Continued From page 9 scream at or curse at other residents, visitors and/or staff." Resident #24 was interviewed on 11/3/15 at 9:18 AM. A quarterly MDS dated 10/11/15 revealed she was cognitively intact and had no behaviors exhibited. Resident #26 reported one of the other residents was verbally abusive. She stated she had been called derogatory names and curse names by Resident #26. She stated she would just move away but most of the time as soon as Resident #26 saw her she would call her names. She stated Resident #26 knew what she was doing because she had even cursed at one of her visitors when the visitor would not give her money for a soda. Resident #3 was interviewed on 11/3/15 at 10:40 AM. Her quarterly MDS dated 10/4/15 revealed she was cognitively intact and had no exhibited behaviors. She stated Resident #26 had called her a curse name. Resident #3 stated she had given another resident 2 flower pots and when that resident died she asked the DON for permission to get the flower pots back. Resident #3 stated Resident #26 cursed at her and called her curse names and a liar over the flower pots. She stated the cursing and derogatory name calling was worse now than in the past. She stated being cursed at by Resident #26 made her feel bad. A review of the incidents provided by the facility revealed the use of Behavior Outburst Forms which were used to document "Assault of Another Resident or Staff Member". A review of a Behavior Outburst Form dated 6/25/15 at 3:00 PM revealed Resident #26 called Resident #3 curse names but Resident #3 did not curse back but stated Resident #26 was a "bad person". The nurse then removed Resident #26	F 226	employees will receive copy of Abuse Policies and will be educated on these policies during their 90 day probation period. (DON, ADON, SDC - 12/11/15) 2.) The MDS nurse will ensure that care plans and MDS reflect most current situations. (12/10/15) 3.) Nurses will receive educational guidance on dealing with resident to resident abuse through one on one and group discussions as incidents occur. They will continue to complete incident/accident report and Behavioral Outburst as indicated. Documentation in EMR for 72 hours per facility policy. (Charge Nurse - 12/11/15) 4.) Monitoring Performance: a.) Social worker will maintain grievance/complaint log and report weekly at Risk Meeting any incident which is abuse to the committee. A detailed written report will be presented monthly to the QAC committee. Goals: 1. To reduce by 50% the number of resident to resident incidents 2. 100% compliance with Abuse Prevention/Investigation Policies 3. SDC will monitor participation in in-services and will inform	

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F 226	Continued From page 10 from the nursing station. The form went on to document the incident had occurred 2 or more times within the past week. The staff action was documented as removed resident and that the nurse explained to the resident the importance of respect for fellow residents. To avoid such an incident in the future was documented as remove resident during outburst. The form was reviewed by the Director of Social Services who documented she spoke with Resident #26 about her behaviors and told her how offensive her name calling was. The Director of Nursing (DON) reviewed the form and documented the resident was removed from other residents temporarily. The DON also documented Resident #26 had had several episodes of verbal aggression that week and that no amount of talking to or trying to reason with her helped. On 11/5/15 at 7:32 AM Nurse #3 reported she had heard Resident #26 call another resident a curse word. She stated she explained to Resident #26 it was inappropriate to call others curse names. She added that Resident #26 would get mad because she did not get her way and would curse at anyone. On 11/5/15 at 10:25 AM the Director of Nursing (DON) reported there were no allegations of abuse investigated since the last annual survey (12/19/15). On 11/6/15 at 11:19 AM the Activities Director (AD) stated last week she heard Resident #26 call Resident #28 a curse name. The AD stated it was verbal abuse when Resident #26 called other residents names. She stated she did not complete a Behavior Outburst Form or notify the DON. On 11/6/16 at 11:28 AM the Director of Social Services (DSS) stated she witnessed when Resident #26 cursed at Resident #3 calling her a	F 226	administrator of any departments or employees who fail to attend. (Administrator, DON, SDC - 12/23/15)	

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	345431	A. BUILDING _____ B. WING _____	11/13/2015

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F 226	Continued From page 11 curse name. She stated. "It was bad verbal abuse." She stated did not complete a Behavior Outburst Form. She stated the facility had arranged for Resident #26 to get help from an outpatient psychiatric physician. She did not report the incident as verbal abuse to the DON or the Administrator. On 11/6/15 at 12:25 PM the DON reported resident #26 had cursed at other residents. She added that it would be considered verbal abuse for a resident to call another resident curse or derogatory names.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to cover an exposed resident (Resident #33) who could be seen from the hall for 1 of 2 residents reviewed for dignity. The findings included: Resident #33 was admitted to the facility on 3/5/12. Diagnoses included Alzheimer's disease. The most recent Minimum Data Set (MDS) dated 9/19/15 revealed the resident had severe cognitive impairment, required limited assistance with transfers and was independent in walking in his room. On 11/4/15 at 7:58 AM, Resident #33 was observed from the hallway sitting on the edge of his bed with his breakfast tray in front of him on	F 241	1.) Corrective action for resident #33: The resident is up and dressed each morning in pajama pants and shirt for breakfast in order to maintain their dignity. The nursing staff has been made aware that he is not to be left on the edge of the bed with an incontinent brief and a t-shirt. The room will be at a temperature which is comfortable for both residents in the room. 2.) Correction action will be accomplished for other residents with the potential to be affected by:	12/22/15

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F 241	Continued From page 12 the tray table. He was wearing a T-shirt and incontinent brief. He had no other covering. His sheet and spread were observed at the foot of the bed. The air conditioner unit was approximately 12 feet from the resident and blowing on him. His arms were crossed tightly and his shoulders were hunched forward. Nursing Assistant (NA) #2 was observed to enter the room, turn off the air conditioner and exit the room. At 8:03 AM NA #3 was observed to enter the room, encourage the resident to eat and exit the room. At 8:15 AM NA #3 returned, pulled up a chair next to the resident and sat to feed him. She place a towel in his lap that obscured the view of the incontinent brief. On 11/4/15 at 8:35 AM, NA #3 was observed from the hall wiping off the tray table. The towel had been removed from Resident #33's lap. He remained sitting on the edge of the bed exposed in the incontinent brief. NA #3 completed wiping the table and left the room. She was interviewed at this time. NA #3 indicated she thought the resident would be ok if left sitting on the edge of the bed. When asked specifically about exposure, NA #3 indicated she could see if he wanted to lie down so she could cover him. She stated he was scheduled to get a shower that morning and would get dressed afterwards. During an interview on 11/6/15 at 8:39 AM, NA #2 recalled turning off the air conditioner in the resident's room on 11/4/15. He stated he did not notice that the resident was exposed in his incontinent brief. During an interview on 11/6/15 at 12:19 PM, the Director of Nursing (DON) stated she expected residents to be covered when visible from the hall and not be seen in an incontinent brief.	F 241	a.) Having residents appropriately dressed when out of bed or appropriately covered to avoid exposure of the residents. b.) Curtains will be pulled to avoid exposure of residents and to maintain dignity. c.) The DON or the ADON will ensure that dignity is maintained thru random observations, especially at mealtimes, of residents rooms. This will be done on a daily basis. d.) Nursing staff has been in-serviced on privacy and dignity and respect of individuality. ADON, Staff Development Coordinator (SDC) 12/11/15, 12/14/15, 12/15/15 3.) Measures put into place to ensure that this practice will not occur: a.) In-service education provided to staff on dignity and respect. (ADON, SDC - 12/11/15, 12/14/15 & 12/15/15) b.) Monitoring for compliance by observation of 10% of the residents when they are up and out of bed that they are properly attired as to avoid exposure. Observations will be done on a daily basis through Ambassador Rounds. Ambassador rounds are done by various members of the facility staff using their Ambassador Rounds forms which allows them to check many aspects of each resident's quality of care, including but not	

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F 241	Continued From page 13	F 241	limited to dignity and respect. (ADON, SDC, MDSC, SW, CFO) c.) Address with staff immediately if problems are seen during the ambassador rounds. Correct the problem with explanation of resident's rights as is pertains to the dignity of the resident to prevent continued practice. (DON, ADON, SW, SDC - 12/11/15) 4. Monitoring performance and compliance: a.) Any problems identified by the Ambassador Rounds will be brought to the monthly Quality Assurance Committee (QAC). Of the 10% of the resident observation, expectation is that there will be 100% compliance. The DON or ADON will present a detailed report to the QAC until substantial compliance has been determined and revisited in 3 months for continued compliance. The report will include the problems, any trends, and corrective action taken (DON, ADON - 12/22/15)	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		12/22/15

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F 278	Continued From page 14 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 3 residents (Resident #52 and Resident # 33) reviewed for falls. The findings included: 1. Resident #52 was re-admitted to the facility on 6/13/2015 with diagnoses to include weakness, irregular heartbeat, and stroke. An incident/accident report dated 8/8/2015 documented a fall at 8:45 PM. No injury was recorded. The residents most recent MDS, dated 9/26/2015, indicated no falls since admission. On 11/6/2015 at 11:56 AM, an interview was conducted with the MDS nurse, who stated he should have coded the MDS with a fall, and it was an oversite.	F 278	1.) Corrective action for residents #52 and #33: Minimum Data Set (MDS) has been corrected to include #52 8/8/15 fall without injury and resident #33: 5 of the 6 falls without injury were corrected and MDS resubmitted. 2.) Corrective action accomplished for those residents having potential to be affected: a.)MDS nurse will review all accident/incident reports to ensure that MDS is coded accurately. (12/11/15) b.) All accident/incident reports will be brought to the weekly Risk Meeting to	

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F 278	Continued From page 15 2. Resident #33 was admitted to the facility on 3/5/12. Diagnoses included Alzheimer's disease and anxiety. Fall reports were reviewed for Resident #33 and revealed the resident fell on 7/1/15, 7/26/15, 7/31/15, 8/2/15, 8/22/15 and 9/13/15. Of the 6 falls, the resident sustained a minor laceration during 1 fall and no injuries during the remaining 5 falls. The quarterly MDS dated 9/19/15 indicated the resident had no falls with no injury, one fall with minor injury and no falls with major injury since the last assessment (a quarterly MDS dated 6/19/15). During an interview on 11/6/15 at 11:16 AM, the MDS nurse indicated he overlooked coding the falls without injury.	F 278	ensure that all Interdisciplinary Team members are made aware of any resident falls and will be coded on MDS. (12/8/15) 3.) Measures put into place to ensure that MDS is coded correctly for residents #55, #33, and others: a.) MDS nurse will maintain a list of all residents who have fallen, with and without injury. The list will be used as a tool for accurate MDS coding. This list includes resident's name, date, type of incident or injury. (MDSC - 12/8/15) b.) All accident/incident reports will be reported at weekly Risk Meeting for discussion. (DON - 12/8/15) c.) Continue Morse Fall Scale (MFS) on admission of all new residents. The MFS will be reviewed and updated quarterly by the MDS nurse. d.) Initiation of Falls Management Program for more accurate follow-up of any fall. The Falls Management Program will monitor trends, precipitating factors such as medications, inappropriate footwear, time of day with a more thorough falls investigation. (MDS Nurse - 12/23/15) e.) The DON or ADON will review MDS's with the MDS nurse to ensure that falls have been coded accurately. Corrections will be made if needed prior to submission (12/16/15).	

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F 278	Continued From page 16	F 278	f.) Will schedule MDS nurse for next available MDS training class provided by Nursing Home Licensure and Certification. (MDS Nurse) The DON or ADON will monitor the MDS for accuracy thru the use of a check-off sheet which includes resident's name date MDS was reviewed and by whom. The MDS's to be reviewed will be those of resident's who have had falls during the MDS period. The DON will report monthly to the QAC the findings of the MDS review with corrective action taken as needed to ensure that MDS is accurate and complete. (DON - 12/16/15)	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		12/22/15

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F 279	Continued From page 17 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to care plan hospice for 1 (Resident #27) of 1 resident reviewed for hospice and failed to care plan antipsychotic medication for 1 (Resident #61) of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #27 was admitted to the facility on 1/6/14. Diagnoses included colitis. On 6/23/15 a significant change Minimum Data Set (MDS) was done due to initiation of hospice services. The care plan, last reviewed on 10/7/15, revealed no care plan related to hospice services although the resident continued to receive hospice services. During an interview on 11/6/15 at 11:22 AM, the MDS nurse indicated he overlooked adding hospice services to the care plan. During an interview on 11/6/15 at 12:17 PM, the Director of Nursing (DON) stated she expected hospice to be care planned when initiated. 2. Resident #61 was admitted to the facility on 10/9/15. Diagnoses included schizophrenia and depression. Physician orders dated 10/9/15 included Risperdal (an antipsychotic drug) 3 milligrams daily and Remeron (an antidepressant drug) 30 milligrams daily. The care plan dated on 10/22/15 revealed a care plan for the antidepressant but none for the antipsychotic drug. During an interview on 11/6/15 at 11:06 AM, the MDS nurse stated he thought care planning the	F 279	1.) Corrective action for resident #27: A care plan has been developed to include Hospice services. (MDS - 11/9/15) Corrective action for resident #61: A care plan has been added to include the antipsychotic medication, Risperdal. (MDS nurse - 11/18/150 2.) Corrective action will be accomplished for those residents having potential to be effected by: a.) Review of Medication Administration Record (MAR) or review of Antipsychotic Medication usage sheet provided by consultant pharmacist monthly. b.) Any residents receiving an antipsychotic medication will have care plan to include the medication and reason for use as well as obtainable and measurable goal(s)and interventions/approaches which are individualized. c.) A care plan for hospice will be initiated within 24 hours of resident admission to Hospice. The MDS nurse will coordinate this care plan with the Hospice RN. (MDS Nurse & Interdisciplinary Team Members (IDT)- 12/16/15) 3.) Measures in place to ensure that care	

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F 279	Continued From page 18 antidepressant would cover the antipsychotic also.	F 279	plans are initiated for any resident admitted to Hospice or any resident receiving antipsychotic medication(s). a.) Facility Social Worker will provide written notice to MDS nurse, DON, Administrator, Pharmacist, Dietary and Business office any time a resident is admitted to Hospice. b.) Care plan for Hospice will be initiated within 24 hours by the MDS nurse. (12/8/15 - ongoing) c.) MDS nurse will review physician orders, MAR, and 24 hour report daily for new orders and will proceed to care plan as indicated. (MDS Nurse - 12/8/15 - ongoing) d.) The DON or ADON will review care plans when new orders are received for Hospice or for antipsychotic medication to ensure these issues have been addressed. (DON, ADON - 12/16/15) 4. Facility will monitor for compliance by: a.) The DON will present a report at the monthly QAC on findings of the care plan review. Any problems encountered will be discussed and resolved. Initially 100% of the care plans will be reviewed by 12/23/15 to ensure compliance for antipsychotic medication usage and to ensure residents who are receiving Hospice services maintain compliance with care plan. (DON - 12/23/15)	

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F 279	Continued From page 19	F 279	b.) The DON will monitor/review 10% of the care plans weekly with written report to QAC monthly until substantial compliance is sustained, and three months later to ensure documented compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed revise a care plan to include a method of securing an indwelling urinary catheter for 1 (Resident #27) of 1 resident reviewed for urinary catheters.	F 280	Corrective Action: 1.) For resident #27, the care plan has been updated to include securing the catheter to the residents thigh using paper	12/22/15

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F 280	Continued From page 20 The findings included: Resident #27 was admitted to the facility on 8/31/12. Diagnoses included neurogenic bladder, chronic indwelling urinary catheter and colitis. A physician order dated 9/26/14 included, "Secure foley cath to leg with paper tape." The care plan, last reviewed 10/7/15, revealed a problem "Resident requires an indwelling urinary catheter R/T (related to) neurogenic bladder." Goals included "Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma" with a goal target date of 1/7/16. Approaches included an undated entry, "Do not use cath straps r/t skin breakdown". No approach was included regarding securing the catheter. During an interview on 11/6/15 at 11:22 AM, the MDS nurse indicated securing catheters was usually care planned.	F 280	tape. (12/1/15) 2.) Care plans for other residents have been reviewed and have been updated as needed to ensure that approach for securing catheter is addressed. New residents who are admitted with a catheter will have a care plan initiated addressing approaches to include securing the catheter. (MDS nurse - 12/10/15 - ongoing) Measures put into place to ensure practice does not continue: 3.) The DON or the ADON will review 100% of care plan of residents with catheters quarterly. Newly admitted residents with catheters will be reviewed within the first 7 days to ensure care plan has been initiated by the MDS nurse. (DON, ADON, MDS nurse - 12/16/15) Monitoring Performance: 4.) The DON or the ADON will present a written report to QAC monthly until compliance is achieved, results of the care reviews goal is 100% compliance. Any problems noted will be addressed immediately and corrected. (DON, ADON, SDC - 12/16/15)	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		12/22/15

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F 282	Continued From page 21 care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement the use of a floor mat as care planned for 1 of 3 residents (Resident #52) reviewed for falls. The findings included: Resident #52 was re-admitted to the facility on 6/13/2015 with diagnoses to include weakness, irregular heartbeat, and stroke. The resident's most recent quarterly Minimum Data Set (MDS) assessment dated 9/26/2015, revealed her cognition to be intact. She required extensive to total assistance for activities of daily living, and was always incontinent with bladder and bowel. An incident/accident report dated 10/2/2015 documented a fall at 5:45 AM. The description of what happened read "slid off side of bed to floor mat." Resident was alert with confusion. Nurse's note dated 10/2/2015 at 6:36 AM revealed the resident was found lying on the fall mat at 5:45 AM. The resident stated she thought it would be nice to use the bathroom for a change. When resident was reminded she couldn't walk, resident replied "I know that now." An incident/accident report dated 10/6/2015 documented a fall at 5:01 AM. The comments indicated the fall mat was in place. The resident's care plan, last updated on 10/15/2015, included an approach of "fall mat beside bed to prevent injury from fall." The report indicated the resident stated she wanted to get up and turned over and slipped out of bed. In an interview with Resident #52 on 11/4/2015 at 12:53 PM, she stated she was ready for a nap.	F 282	1.) For resident #52 a fall mat is placed at bedside when this resident is in bed. The fall mat is addressed in the resident's care plan. (MDS nurse - 11/6/15) 2.) For other residents with the potential to be affected: a.) Morse Fall Score will be done on all residents within 24 hours. Residents with score of 25 or greater are considered to be at risk for falls. Care plan will be initiated with the following interventions/approaches to include fall mat to floor, low bed or bed in lowest position, gripper socks, mobility/assistive devices such as cane, walker, wheelchair as needed. In addition referral to physical therapy (PT), occupation therapy(OT) or restorative nursing as needed if indicated. (DON, ADON, SDC, MDS nurse - 12/1/15) Measures in place to prevent reoccurrence: 3.) Continue identification of residents who are at risk for falls through MFS. Review of incident/accident reports on a daily basis by DON and MDS nurse to ensure care plans are initiated or updated as needed. The DON or the ADON will monitor the care plans on a weekly basis for those residents with incident/accidents	

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F 282	Continued From page 22 The resident stated she had fallen before because she thought she could walk to the bathroom, but she found out she couldn't. She indicated she was supposed to use her call light for help. The bed was observed to be in low position with no side rails, and no fall mat was in the room. An interview was conducted with nursing assistant (NA #1) on 11/4/2015 at 2:49 PM. She stated the resident had not had any falls recently, and had no special precautions for preventions of fall injuries. An interview was conducted on 11/4/2015 at 3:44 PM with the nurse (nurse #1), who stated the resident had some falls, and had a fall mat by her bedside. She indicated the fall mat had been in place since September. On 11/4/2015 at 5:02 PM, an interview was conducted of Resident #52, who was lying in bed. She stated she wanted to get up and go to therapy. No fall mat was in her room. On 11/5/2015 at 7:36 AM, an observation was conducted on Resident #52, who was sitting up in bed eating breakfast. No fall mat was in her room. An interview was conducted with nurse #2 on 11/5/2015 at 10:25 AM. The nurse stated the resident was on fall precautions, and had a floor mat to her bedside. She stated she was moved to her present room on 10/13/2015. An interview was conducted with the MDS nurse on 11/5/2015 at 11:42AM, who stated he had updated the residents care plan to include a fall mat, and it had not been discontinued. An interview was conducted with the Director of Nursing (DON) on 11/5/2015 at 12:39 PM, who stated she expected the fall mat to be in the room and be used.	F 282	reports to ensure that the care plan has been initiated or updated with appropriate goals and interventions that are specific for each individual resident. Care plan audit/review will be done using checklist which includes the resident's name, type of incident, who reviewed the care plan, date care plan updated or initiated and a comment section.Reviews will be done weekly and will continue on an on-going basis. Monitoring for fall mats, low beds etc. for 10% of residents that are at risk for falls will be done through ambasador rounds daily. (DON, ADON) 4.) The DON will submit a report to Risk Meeting weekly with a detailed written report to QAC monthly of all incidents occurring during previous month. Information for the report will be obtained from the care plan checklist. The report includes trends, number of incidents and any corrective action(s) taken.F282 will contine to monitored and reported on monthly until such time as the committee feels the problems have resolved. A revisit of F282 will be done 3 months later to ensure problems have not reoccurred and compliance has been maintained. (DON,ADON) 12/22/15 Threshold for compliance: 100% (DON - 12/23/15)	

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F 315	Continued From page 23	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to secure an indwelling urinary catheter as ordered for 1 (Resident #27) of 1 resident reviewed for urinary catheters. The findings included: Resident #27 was admitted to the facility on 8/31/12. Diagnoses included neurogenic bladder, chronic indwelling urinary catheter and colitis. A urology consultation report dated 7/31/14 read in part, "Penis split from meatus to glans." A physician order dated 9/26/14 included, "Secure foley cath to leg with paper tape." The care plan, last reviewed 10/7/15, revealed a problem "Resident requires an indwelling urinary catheter R/T (related to) neurogenic bladder. Goals included "Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma" with a goal target date of 1/7/16. Approaches included an undated entry, "Do not use cath straps r/t skin breakdown". No approach was included regarding securing the catheter.	F 315	Corrective action to resident #27. 1.) Resident #27's catheter has been secured with tape and is checked at least every 12 hours by the licensed nurse to ensure stability and to check for skin irritations. (MDS nurse, SDC RN - 11/8/15) 2.) Corrective action for others with potential to be affected: a.) Residents with catheters will have a care plan written to include goal appropriate for the specific resident(s) i.e., "Catheter care managed appropriately as to prevent pulling and to prevent trauma." Each resident will be assessed for use of leg strap or tape depending on the individual need(s) of the resident(s). (MDS nurse)	12/22/15

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F 315	Continued From page 24 On 11/5/15 at 8:02 AM, the resident was observed while receiving a bath given by the Nursing Assistant (NA) from Hospice and NA #4. When the resident was exposed from the waist down, the catheter was not secured in any fashion. The penis was split from the meatus to the glans in the posterior aspect. After the bath was completed, the catheter was not secured. NA #4 was interviewed on 11/5/15 at 8:40 AM. She stated she usually put tape on the resident's leg to secure the catheter. NA #4 added that they were not to use leg straps on him. NA #4 was then observed to tape the catheter to the resident's leg. During an interview on 11/6/15 at 10:41 AM, the Staff Development Coordinator (SDC) indicated she was responsible for weekly skin assessments for all residents. She stated they had used a leg band in the past to secure Resident #27's catheter but it caused pressure and was stopped. The SDC said they had also used tape but the resident would get little blisters. She stated now they put tape on it every once in a while to secure it. During an interview on 11/6/15 at 12:13 PM, the Director of Nursing (DON) stated she expected urinary catheters to be secured to prevent pulling.	F 315	b.) Certified Nursing Assistants (CNA's) and licensed nurses have been instructed on how to properly secure a catheter. (ADON, DON - 12/11/15, 12/14/15, 12/15/15) c.) For those residents currently in the facility and have either indwelling foley or suprapubic catheter, a bowel and bladder evaluation is completed. (12/11/15) 3.) Measure put into place to ensure compliance: a.) All residents will have Bowel and Bladder Evaluation (B&B eval) done on admission. This evaluation will be reviewed and updated quarterly as needed. MDS nurse will assume responsibility for initiation and completion of B&B evaluation and will generate a care plan for the resident(s) based on the results of the evaluation and the individual need(s) of the resident(s). b.) Catheter care, including properly securing the catheter, will be on the Treatment Administration Record (TAR) and the licensed nurse will initial on each shift (every 12 hours) to indicate catheter care was done. (MDS nurse, Licensed nurses - 12/15/15)	

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F 315	Continued From page 25	F 315	c.) The DON or the ADON will review 100% of the TAR's of residents with catheters weekly to ensure compliance is sustained. d.) Additionally, the DON, ADON, MDS nurse or SDC will check resident #27 and other residents with catheters daily to be sure catheters are secured as per their care plan. (12/15/15) 4.) Monitoring compliance: a.) The information obtained from TAR reviews and resident observations will be compiled into a written report and will be presented to QAC monthly until substantial compliance is maintained. Negative findings will have corrective action taken by QAC and changes will be made to TAR or resident care plan as needed. (MDS nurse, SDC RN - 12/22/15)	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		11/14/15

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F 323	Continued From page 26 Based on observation, staff and resident interview and record review, the facility failed to possess manufacturer instructions for the van securement system; failed to properly secure wheelchairs to the floor securement system for 2 of 2 alert and oriented residents (Residents #24 and #49), failed to monitor securement of wheelchairs in the facility van and failed to have a process to ensure the securement system was in good working order for 1 of 1 facility van. Immediate Jeopardy began on 9/17/15 when 2 of 2 alert and oriented residents (Resident #24 and Resident #49), who were transported in their wheelchairs in the facility van on a social outing, stated their wheelchairs did not feel securely fastened. Immediate jeopardy was removed on 11/13/15 at 5:27 PM when the facility provided and implemented a credible allegation of compliance that included the permanent removal of the van from service. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure implementation of the change in process in arranging for transportation for appointments and activities events. The findings included: An online document regarding the facility van securement system entitled "Operation Instructions" for [name of company and identifier of product series] read in part, "Secure the Wheelchair" "2. Attach the Front Tie-Downs" "The front tie-downs need approximately a 45 degree angle from the floor. Install the track fitting into a floor track." "Pull on fitting to ensure it is properly locked in the track." "Loop the other end of the tie-down around a solid structural frame member of the wheelchair as close to the corner junction	F 323	The Our Community Hospital van used for resident transport has been taken out of service permanently effective November 6, 2015. All wheelchair residents are being transported by a transport service. The wheelchair tie-down straps have been removed from the van. No activities will be missed and an outside transport company will be used for activities and appointments. Activities Director and transporter have been notified of the decision. All resident appointments have been and will continue to be arranged through several transport services within the area. The appointment book for residents is checked twice daily to ensure that no appointments have been missed and that transport has been confirmed.There is a checklist in the front of the appointment book which the nursing staff uses to ensure that all measures, such as notification of transport company, notification of family, appointment confirmed with MD office. In the event of scheduled outside activities, the facility will attempt to arrange transportation using the services of a transport company within the area. The DON or the ADON will review the appointment log weekly to ensure that all appointments have been met. The activity director will notify the DON or the ADON for scheduled outings or other activities scheduled outside the facility so that transportation arrangements can be made. The DON or ADON will present a written	

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F 323	Continued From page 27 of the seat cushion as possible and connect hook to the D-ring." "Pull loose end of tie-down through the buckle, until tight. Repeat with other front tie-down." "3. Attach the Rear Tie-Downs" "The rear tie-downs need approximately a 45 degree angle from the floor. Install the track fitting into a floor track." "Pull on fitting to ensure it is properly engaged in the track." "Loop the other end of tie-down around a solid structural frame member of the wheelchair as close to the corner junction of the wheelchair back and seat as possible, and connect hoot to the D-ring (for S-hook tie downs, see step 4). Unlock buckle and rotate handle to open position, pull loose end of tie-down to remove slack, rotate handle to closed locked position to tension the tie-down. Repeat with other rear tie-down." "4. S-hooks" "Place the S-hooks around a solid structural from member of the wheelchair as close to the corner junction of the seat cushion as possible and apply tension to the tie-down." The text following step 4 was enclosed in a box and was in bold print: "Caution: Do not attach tie-downs to the wheels or any detachable portion of the wheelchair. Tie-down must have a clear, straight path from floor to where it attaches to the wheelchair." "5. Attach the Lap Belt" "Place the ends of the lap belt around the occupant. Thread them down and through opening between wheelchair side panel and seat, or through gap between wheelchair back and seat." During an interview on 11/5/15 at 9:12 AM, Nursing Assistant (NA) #3 indicated it was her responsibility to transport residents in the facility van. She stated she believed the van needed new buckles for strapping in the wheelchairs as she did not have the strength in her hands to operate the buckles. NA #3 said she reported problems she was having with the buckles to someone in	F 323	report to the QAC of any problems regarding scheduling appointments or activties. F323 will be monitored and reported monthly at QAC until such time as the committe feels that the problems are resolved. A revisit will be done three months late to ensure compliance is maintained. DON, ADON 12/22/15	

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maintenance but could not recall who or when. She indicated nothing had been done.
On 11/5/15 at 9:15 AM NA #3 demonstrated how she secured wheelchairs in the van. (For the purpose of the demonstration, she only secured one side of the wheelchair.) She was observed to lock the wheelchair near the tracks on the floor into which the straps from the securement system were locked. NA #3 first wrapped one securement strap around the front aspect of the wheelchair frame and fastened it above the wheel via snap hook into D-ring. NA #3 attempted to tighten the strap but stated it did not stay tightened. She demonstrated this by pulling on the strap to tighten it and pointing out how it immediately loosened. Next, NA #3 wrapped the securement strap, locked into the rear track, between 2 spokes of the back wheel. She said she did not have the strength to operate the buckle that allowed for strap length adjustment and tightening. Finally, NA #3 applied the belt located on a track on the side wall of the van approximately at shoulder/head level. She ran the strap through the space between the arm and metal side of the chair, across the lap, through the opposite side space between the arm and metal side and hooked the belt in the D-ring. NA #3 indicated she was trained on securing wheelchairs by the former driver and she had been driving the van for the last 7-8 years. NA #3 stated she had never experienced any incidents or accidents when transporting residents but worried that something could happen due to them not being properly secured, although she did the best she could.
The Director of Facility Operations (DOFO) was interviewed on 11/5/15 at 9:32 AM. He stated NA #3 was the only person who drove the van. The DOFO indicated he did some maintenance on the

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wheelchair securing system about a year ago and was not aware of any further problems. He also said his department did not perform any routine checks of that system but relied on the driver to make him aware if she had concerns. The DOFO added that he was not aware of any current problems.

On 11/5/15 at 9:56 AM, Resident #24 was interviewed. Her quarterly Minimum Data Sets (MDSs) dated 7/11/15 and 10/11/15 revealed she was cognitively intact and had no behavioral problems. The resident indicated she rode in her wheelchair in the facility van on several occasions, the last being about 3 weeks ago on a pleasure outing. The resident stated her chair did not feel secured because it rocked back and forth and side to side. Resident #24 said she felt fearful that the wheelchair would come loose.

On 11/5/15 at 10:06 AM, Resident #49 was interviewed. His quarterly MDSs dated 5/14/15 and 8/14/15 revealed he was cognitively intact and had no behavioral problems. The resident indicated he rode in his wheelchair in the facility van. He indicated the wheelchair wobbled from side to side. The resident indicated he last rode the van in a group outing in September.

On 11/5/15 at 1:30 PM, the DOFO and Facility Operations Staff (FOS) #1 were observed in the van rearranging the location of the securement straps in the floor tracks. The DOFO was observed adjusting the length of the strap for one of the rear wheels by pulling very hard on the strap. Both he and FSO #1 said it should not be that difficult to adjust the straps. FSO #1 went on to demonstrate how to secure a wheelchair in the van. The process observed was different from that of NA #3's process in that the straps were not wrapped at any point and were tightened after being fastened.

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During an interview on 11/5/15 at 4:00 PM, the Administrator indicated the he was unable to locate any information about the van with the manufacturer's specifications for the wheelchair securement procedure. He explained the van was used when purchased, approximately in 2001, and the seller showed the former facility driver how to secure the wheelchairs. The Administrator stated the driver was responsible for securing the wheelchairs and had been trained by the previous driver who retired some years back. The facility had no periodic review procedure to validate the equipment was functioning properly and that the driver was securing the wheelchairs properly. The Administrator added the facility had had no accidents or incidents with the van.

During an interview on 11/6/15 at 11:47 AM, the Director of Nursing (DON) stated that the facility frequently used outside transport services for medical appointments and the facility van was used mainly for resident outings. She stated that the van would remain out of service until all safety concerns had been resolved or a decision reached to permanently stop using that van.

A follow-up interview was conducted with Resident #24 on 11/13/15 at 10:10 AM during which she repeated the information provided on 11/5/15. During an interview on 11/13/15 at 10:30 AM, the Assistant Director of Nursing (ADON) indicated Resident #24 was alert, oriented and reliable. During an interview on 11/13/15 at 10:35 AM, the Activities Director (AD) indicated Resident #49 was alert, oriented and reliable.

A follow-up interview was conducted with Resident #49 on 11/13/15 at 10:02 AM. He repeated that his wheelchair wobbled from side to side when he rode in the van. During an interview on 11/13/15 at 10:33 AM, the ADON indicated

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Resident #49 was alert, oriented and reliable.
During an interview on 11/13/15 at 10:35 AM, the AD indicated Resident #49 was alert, oriented and reliable.
During a follow-up interview on 11/13/15 at 10:43 AM, the DOFO indicated he recalled some time ago, unsure of when, NA #3 had a problem with one of the buckles. He found the strap to be twisted in the buckle. He untwisted the strap and the problem was solved. The DOFO said the securement system is very basic and should not require routine maintenance. The DOFO indicated he was not aware of manufacturer instructions for inspection and maintenance of the securement system. He stated it was the responsibility of the driver to report any concerns to him.
On 11/13/15 at 11:10 AM a follow-up interview was conducted with NA #3 via telephone. She indicated she believed the securement straps needed new buckles because the current buckles were so difficult to use. NA #3 said she had no specific checklist to follow to verify the securement system was OK.
On 11/13/15 at 4:05 PM, the AD indicated she had recently been told the facility no longer had a van to transport residents on outings. She added that no activities requiring resident transport were scheduled at this time.
On 11/13/15 at 5:05 PM, the facility van was observed with no straps/securements present.
On 11/13/15 at 5:15 PM the administrator was observed to remove the van keys from the nurses' station and lock them in a drawer in his office. He stated maintenance had the other set of keys in their office.
The administrator was notified of immediate jeopardy on 11/13/15 at 2:36 PM.
On 11/13/15 at 5:27 PM the facility provided the

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OUR COMMUNITY HOSPITAL	921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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F 323	Continued From page 32 following credible allegation: "The Our Community Hospital van used for resident transport has been taken out of service permanently effective November 6, 2015. All wheelchair residents are being transported by a transport service. The wheelchair tie-down straps will be removed from the van. No activities will be missed and an outside transport company will be used for activities and appointments. Activities Director and transporter have been notified of the decision." The Credible Allegation was validated on 11/13/15 at 5:30 PM. A telephone interview with NA #3 revealed she had been made aware that the facility van was no longer to be used for resident transport. An interview with the AD revealed she had been made aware that the facility van was no longer to be used for resident transport, and that the facility would use an outside transport service when outings were scheduled.	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have or procure manufacturer instructions for the inspection and maintenance of the wheelchair securement system, failed to provide the Director of Facility Operations with	F 490	The Our Community Hospital van used for resident transport has been taken out of service permanently effective November 6, 2015. All wheelchair residents are being transported by a	11/14/15

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F 490	Continued From page 33 maintenance instructions for the securement system, failed to provide clear expectations and training for the use of the securement system, failed to develop a checklist for safe wheelchair securement, and failed to ensure driver competency in wheelchair securement procedures for 2 of 2 alert and oriented residents (Residents #24 and #49) and 1 of 1 facility van. Immediate Jeopardy began on 9/17/15 at 9:00 AM when 2 of 2 alert and oriented residents (Resident #24 and Resident #49), who were transported in their wheelchairs in the facility van on a social outing, stated their wheelchairs did not feel securely fastened. Immediate jeopardy was removed on 11/13/15 at 5:27 PM when the facility provided and implemented a credible allegation of compliance that included the permanent removal of the van from service. The findings included: Cross refer to F323: Based on observation, staff and resident interview and record review, the facility failed to possess manufacturer instructions for the van securement system; failed to properly secure wheelchairs to the floor securement system for 2 of 2 alert and oriented residents (Residents #24 and #49), failed to monitor securement of wheelchairs in the facility van and failed to have a process to ensure the securement system was in good working order for 1 of 1 facility van. The administrator was notified of immediate jeopardy on 11/13/15 at 2:36 PM. On 11/13/15 at 5:27 PM the facility provided the following credible allegation: "The Our Community Hospital van used for resident transport has been taken out of service permanently effective November 6, 2015. All wheelchair residents are being transported by a transport service. The wheelchair tie-down straps	F 490	transport service. The wheelchair tie-down straps have been removed from the van. No activities will be missed and an outside transport company will be used for activities and appointments. Activities Director and transporter have been notified of the decision. All resident appointments have been and will continue to be arranged through several transport services within the area. The appointment book for residents is checked twice daily to ensure that no appointments have been missed and that transport has been confirmed.There is a checklist in the front of the appointment book which the nursing staff uses to ensure that all measures, such as notification of transport company, notification of family, appointment confirmed with MD office. In the event of scheduled outside activities, the facility will attempt to arrange transportation using the services of a wheelchair transport company within the area. The DON or the ADON will review the appointment log weekly to ensure that all appointments have been met. The activity director will notify the DON or the ADON for scheduled outings or other activities scheduled outside the facility so that transportation arrangements can be made. The DON or ADON will present a written report to the QAC of any problems regarding scheduling appointments or activties. F323 will be monitored and	

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F 490	Continued From page 34 will be removed from the van. No activities will be missed and an outside transport company will be used for activities and appointments. Activities Director and transporter have been notified of the decision." The Credible Allegation was validated on 11/13/15 at 5:30 PM. A telephone interview with NA #3 revealed she had been made aware that the facility van was no longer to be used for resident transport. An interview with the AD revealed she had been made aware that the facility van was no longer to be used for resident transport, and that the facility would use an outside transport service when outings were scheduled.	F 490	reported monthly at QAC until such time as the committe feels that the problems are resolved. A revisit will be done three months late to ensure compliance is maintained. DON, ADON 12/22/15	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		12/22/15

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F 520	Continued From page 35 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facility's Quality Assurance and Assessment (QAA) Committee failed to maintain implemented procedures and monitoring practices to address the interventions put into place after the 12/19/14 recertification survey and the complaint investigation dated 2/23/15 in order to achieve and sustain compliance. This was for 6 recited deficiencies, 1 which was originally cited during a complaint investigation survey on 2/23/15 and 5 which were originally cited on 12/19/14 during a recertification investigation and on the current recertification survey of 11/13/15. The pattern of repeat deficiencies were in the areas of development/implement abuse policies, dignity, assessment accuracy, development of care plans, participation in care planning and Quality Assurance and Assessment. The continued failure of the facility during two federal surveys of record and a complaint investigation show a pattern of the facilities inability to sustain an effective Quality Assurance and Assessment Program. The findings included: This tag is cross referenced to 1. F226 on the current survey of 11/13/15 - Based on record review and interviews with residents and staff the facility failed to follow their policy and procedure for investigating allegations of verbal abuse for 1 resident (Resident #26) who was calling other residents derogatory names and	F 520	The facility will maintain a Quality Assurance Committee consisting of the Director of Nurses, physician and three members of the staff. The committee will meet monthly to access what quality activities are necessary and monitor corrective action of the identified issues. The deficiencies of surveys 11/13/15, 12/19/14 and complaint of 2/23/15 will be committee's current project and will be monitored and reported on monthly until such time as the committee feels that the problems are resolved. A revisit of the issues will be done three months later to ensure continued compliance. 1.F226 Survey of 11/13/15 a.) Social worker will maintain grievance/complaint log and report weekly at Risk Meeting any incident which is abuse to the committee. A detailed written report will be presented monthly to the QAC committee. Goals: 1. To reduce by 50% the number of resident to resident incidents	

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F 520	Continued From page 36 curse names During a previous complaint survey on 2/23/15 the facility was cited for not thoroughly investigating an injury of unknown origin for 1 of 1 sampled resident (Resident #30). 2. F241 on the current survey of 11/13/15 - Based on observations, staff interview and record review the facility failed to cover an exposed resident (Resident #33) who could be seen from the hall for 1 of 2 residents reviewed for dignity. During the recertification survey of December 2014 the facility was cited for failing to ensure resident's clothing fit and failed to obtain permission prior to entering a resident's room. 3. F278 on the current survey of 11/13/15- Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 3 residents (Resident # 52 & 33) reviewed for falls. During the recertification survey of December 2014 the facility was cited for failure to accurately code dialysis, vision and receiving a diuretic for 3 of 20 residents. 4. F279 on the current survey of 11/13/15 - Based on staff interviews and record review the facility failed to care plan hospice for 1 (Resident #27) of 1 reviewed for hospice and failed to care plan antipsychotic medications for 1 (Resident #61) of 5 residents reviewed for unnecessary medications. During the recertification survey of December 2014 the facility was cited for failure to develop care plans for 2 of 2 residents (Resident #33 & #42) with behaviors, 1 of 1 resident (Resident #43) on dialysis, 1 of 4 (Resident #10) reviewed for nutrition, 1 of 5 residents (Resident #15) reviewed for pain and 1 of 1 residents (Resident #19) reviewed for unnecessary medications.	F 520	2. 100% compliance with Abuse Prevention/Investigation Policies 3. SDC will monitor participation in in-services and will inform administrator of any departments or employees who fail to attend. (Administrator, DON, SDC - 12/23/15) 2. F226 Complaint of 2/23/15 a) The DON will maintain an incident log and report weekly at Risk Meeting any incidents of unknown origin. A detailed written report will be presented monthly to the QAC committee. The committee will monitor the incident reports for complete investigation of 100% of the incidents of unknown origin. F241 Survey of 11/13/15 and 12/19/15 Monitoring for compliance by observation of 10% of the residents when they are up and out of bed that they are properly attired as to avoid exposure. Observations will be done on a daily basis through Ambassador Rounds. Ambassador rounds are done by various members of the facility staff using their Ambassador Rounds forms which allows them to check many aspects of each resident's quality of care, including but not limited to dignity and respect. (ADON, SDC, MDSC, SW, CFO) Address with staff immediately if problems are seen during the ambassador rounds. Correct the problem with explanation of	

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F 520	Continued From page 37 5. F280 on the current survey of 11/13/15 - Based on staff interview and record review, the facility failed to revise a care plan to include a method of securing an indwelling urinary catheter for 1 (Resident #27) of 1 resident reviewed for urinary catheters. During the recertification survey of December 2014 the facility was cited for failure to revise the care plans to reflect new interventions to prevent falls for 2 of 3 residents (Residents #43 and #47) reviewed for falls. 6. F520 On the current survey of 11/13/15 - Based on record reviews and staff and resident interviews the facility's Quality Assurance and Assessment (QAA) Committee failed to maintain implemented procedures and monitoring practices to address the interventions put into place after the 12/19/14 recertification survey. There was a pattern of repeat deficiencies in the areas of development/implement abuse policies, dignity, assessment accuracy, development of care plans, participation in care planning and Quality Assurance and Assessment. During the recertification survey of December 2014 the facility failed to have a Quality Assessment and Assurance program that developed and implemented a plan of action. On 11/6/15 at 12:20 PM an interview was conducted with the facility's Administrator who identified he was the coordinator of the facility's QAA Committee. He stated the facility's QAA Committee met monthly and consisted of the medical doctor, the Director of nursing, the infection control nurse and the wound care nurse. He added that other staff attended as needed based on the agenda. The DON was present during this interview and she provided information on the improvements made in the QAA Committee since the last survey. She was	F 520	resident's rights as is pertains to the dignity of the resident to prevent continued practice. (DON, ADON, SW, SDC - 12/11/15) Monitoring performance and compliance: Any problems identified by the Ambassador Rounds will be brought to the monthly Quality Assurance Committee (QAC). Of the 10% of the resident observation, expectation is that there will be 100% compliance. The DON or ADON will present a detailed report to the QAC until substantial compliance has been determined and revisited in 3 months for continued compliance. The report will include the problems, any trends, and corrective action taken (DON, ADON - 12/22/15) F278 Survey of 11/13/15 and 12/19/14 The DON or ADON will monitor the MDS for accuracy thru the use of a check-off sheet which includes resident's name date MDS was reviewed and by whom. The DON will report monthly to the QAC the findings of the MDS review with corrective action taken as needed to ensure that MDS is accurate and complete. (DON - 12/16/15) F279 Survey 11/13/15 and 12/19/14 The DON will present a report at the monthly QAC on findings of the care plan review. Any problems encountered will be	

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F 520	Continued From page 38 maintaining a book to help streamline the meetings and to ensure all topics from the previous plan of correction were discussed. She stated it was a work in process. They acknowledged they were aware of repeat citations.	F 520	discussed and resolved. Initially 100% of the care plans will be reviewed by 12/23/15 to ensure compliance for antipsychotic medication usage and to ensure residents who are receiving Hospice services maintain compliance with care plan. (DON - 12/23/15) The DON will monitor/review 10% of the care plans weekly with written report to QAC monthly until substantial compliance is sustained, and three months later to ensure documented compliance. F280 Survey of 11/13/15 and 12/19/14 The DON or the ADON will review 100% of care plan of residents with catheters quarterly. Newly admitted residents with catheters will be reviewed within the first 7 days to ensure care plan has been initiated by the MDS nurse. (DON, ADON, MDS nurse - 12/16/15) Monitoring Performance: The DON or the ADON will present a written report to QAC monthly until compliance is achieved, results of the care reviews goal is 100% compliance. Any problems noted will be addressed immediately and corrected. (DON, ADON, SDC - 12/16/15) F520 Survey 11/13/15 and 12/19/14 The actions of the QA Committee will be monitored by the Chairman of the board of trustees and medical director on a	

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F 520	Continued From page 39	F 520	monthly basis through review of the minutes and reports to ensure continued compliance.	